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ABSTRACT

This manual provides essential information for counselors in private practice who are either just starting out or have established practices. It is organized into six sections, which contain forms relating to different aspects of practice. The material can be used to create new forms or adapted for individual use. They can also serve to generate marketing ideas, help work with managed care organizations, and improve billing. Chapter 1 concerns office policy and procedures and contains sample letters to clients on policy, discontinuation of therapy, and other acknowledgements. Chapter 2 deals with billing to insurance companies and individuals. Chapter 3 considers client release and consent forms. Chapter 4 discusses intake, clinical evaluations, and progress monitoring. Chapter 5 presents marketing ideas. Chapter 6 explains how to work with managed care organizations. A CD-ROM accompanies the manual. (JDM)

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The AMHCA Handbook of Essential Forms and Marketing Strategies

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◆ Introduction ◆

This handbook is designed to serve as a resource for counseling professionals from the beginning private practitioner to the experienced clinician/businessperson. It contains many sample forms that may be adapted to suit your particular needs. It also contains suggestions and samples regarding marketing, as well as information on managed care organizations.

You will notice the forms and information presented have been divided into six easily referenced sections. The Table of Contents will provide you with a complete listing of items included. You may use these materials to create new forms, adapt existing ones, generate marketing ideas, help contact managed care organizations, and improve billing procedures, to name only some uses of this guide.

I trust you will find this manual to be comprehensive and easy to use. I have based it on my experience as a private practitioner over the past several years, and hope it will serve to enhance your management, and ultimately your enjoyment of your practice. Thanks for giving this guide a look.

Mark Vellucci

◆ CHAPTER ONE ◆

Office Policy and Procedures

This section includes sample forms, letters, and agreements relating to policies and day to day procedures in a range of areas. Some of these examples may provide you with formats for your form and policy development, and may lead to generation of additional ideas of particular relevance to your practice. An important factor to keep in mind regarding these types of forms and letters is to make sure they remove, rather than add to, any confusion or possibility for misunderstanding between you and your clients.

The following items are included:

- Policy Regarding Missed Sessions
- Payment Waiver
- Special Fee Agreement
- Reminder of Policy Letters
- Discontinuing Treatment (therapist's choice) Letter
- Premature Discontinuance of Therapy Letter to Client
- "Thank You" Letter
- Facsimile Cover Sheet
- Telephone Contact Record
- Borrowing Agreement & Materials Available List

Policy Regarding Missed Sessions

I believe that it is important for clients to attend all sessions scheduled for them, except, of course, in an emergency. Missed or canceled sessions are counterproductive and increase the time it takes to bring about the changes which you entered counseling to make. The policy of this office, therefore, is to bill you for all missed sessions not canceled 24 hours in advance of your appointment. I will try to reschedule these sessions for you during the same week. If you miss a session without notice, I will bill you directly. Insurance and managed care companies rarely, if ever, pay for sessions that you miss and it would be fraudulent for me to submit a claim for these.

Please sign the following statement to indicate that you have read and understood this policy:

> *I have read and understood your policy concerning missed sessions. I understand that I will be billed for all avoidable missed sessions and late cancellations for which I have not given 24 hours notice. I agree to pay for these sessions.*

_____ _____

Client's Signature
(parent if client is a minor)

Date

Payment Waiver

Policy requires payment of counseling fees at the time of service. The amount of your fee and the terms of payment are specified in the Fee Agreement. This Payment Waiver will allow you a one-time exception to that policy. It is expected that you will pay the outstanding amount due on or before the date of your next appointment. If you have an emergency and are unable to make payment, it is important that you notify me so that a satisfactory payment arrangement may be made.

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE, AND THAT THIS PAYMENT WAIVER WILL ALLOW ME TO MEET WITH *PRACTITIONER'S NAME* TODAY ONLY WITHOUT PAYMENT AS AN EXCEPTION TO POLICY. I FURTHER UNDERSTAND THAT I WILL BE REQUIRED TO PAY THE AMOUNT DUE TODAY AND THE AMOUNT DUE FOR THE NEXT SESSION ON OR BEFORE THE DATE OF MY NEXT APPOINTMENT; OTHERWISE, I WILL NOT BE ALLOWED TO KEEP THAT APPOINTMENT.

CLIENT: _____ DATE: _____

Special Fee Agreement

I am desirous of receiving professional care in this office, despite a current financial limitation that would normally preclude my receiving this service. However, this office is willing to provide me with a SPECIAL FEE ARRANGEMENT in an effort to help me receive services.

I agree to pay *Practitioner's Name* _____ per hour of service for the next _____ weeks. After this period expires, this agreement will be reviewed and extended or modified upon agreement of both parties.

I further agree that if for any reason I miss any such payment or the payment is late, this agreement becomes null and void, and all moneys for previous treatment rendered become DUE AND PAYABLE IMMEDIATELY.

Dated _____

Client's Name _____

Client's Signature _____
(parent if client is a minor)

Counselor's Signature _____

(Sample Client Reminder of Policy)

Date

Dear Clients and Friends:

I would like to request your assistance in helping my office run more efficiently. Please be reminded of these procedures:

1. For purposes of liability and security, any child coming to my office for an appointment should be escorted and checked in by an adult. The accompanying adult does not need to remain in the waiting room for the entire session, but is asked to accompany the child to my office reception area. This will avoid any potential for confusion or concern.
2. If you are unable to pay your fee or co-payment at the time of service, please request a waiver form from the office. This will allow a one-time only delay in fee payment.
3. If you need to cancel an appointment, please inform the office at least one day prior to the scheduled time. Failure to do so will result in a full charge of fees for that scheduled time (emergencies are subject to exception of this policy).

Additionally, please understand (as I realize most do) that services requiring time beyond scheduled sessions are subject to the charges as stated in the fee agreement. No additional services will be provided without prior approval from you, excepting emergencies. These charges include telephone calls that exceed 5–10 minutes in length and/or cover areas normally dealt with in session.

Please understand that my goal has been, and will continue to be, to provide caring, professional service. I truly appreciate your confidence and trust, and will endeavor to prove it well-placed. I thank you for your understanding, and look forward to continued positive regard between us.

Sincerely,

Practitioner's Name

(Sample Policy Reminder Letter)

Date

Dear Clients:

In reviewing your monthly statement, you may notice charges for specific services rendered beyond or outside of scheduled sessions. Please refer to your signed fee agreements regarding policies and charges for services. Generally, all requests for contacts with school or other professionals are charged at the rate stipulated on the fee agreement. The same applies for phone contacts with you extending beyond 5-10 minutes in length and/or involving specific therapeutic issues, as well as extended length counseling sessions.

Please understand that it has been and continues to be my wish that no misunderstandings arise regarding charges. I am sometimes lax in enforcing the fee agreement, and in some ways may contribute to an expectation that some services might be made available at no charge that should be charged. This is why I have decided to re-clarify policies in this message.

If you need a copy of your fee agreement or have any questions, please ask.

Thanks,

Practitioner's Name

(Sample Discontinuance of Therapy Letter to Client)

Date

Dear

I am writing to inform you that as of the date of this letter I will no longer be providing counseling services for you and/or your family. If you have already chosen to discontinue working with me, you may have no need for referrals, but if you do require names of other practitioners to whom I could refer you, I would be willing to provide them at your request.

I have appreciated the opportunity to work with you and wish you all the best. Take care.

Sincerely,

Practitioner's Name

(Sample Premature Discontinuance of Therapy Letter to Client)

Date

Dear

In reviewing your case file, I have noticed that it has been more than two months since your last appointment. I have either contacted you directly and/or left messages for you to contact me, yet have not seen you for some time. I am assuming you have chosen to discontinue counseling, and will consider your case closed if I have not heard from you within ten days of the date on this letter.

If you would like to continue your counseling, I would be pleased to continue working with you. If you have had any dissatisfaction or concerns about our work together, please call me—I would appreciate hearing about it. If you would like to schedule one "exit" appointment to help determine where you might go from this point and to review your accomplishments, I would be pleased to arrange a convenient time with you.

I do not necessarily believe that this is the appropriate point for you to discontinue counseling, but I respect your right to decide otherwise. If I may be of any further assistance, please give me a call. I wish you all the best.

Sincerely,

Practitioner's Name

(Sample Thank You Letter to Client)

Date

Dear

I wanted to let you know I have appreciated the opportunity to work with you during our counseling time together. I am hopeful that you feel it has been a worthwhile experience. If I may be of any assistance in the future, please feel welcome to give me a call.

Thank you for choosing to work with me. I wish you the very best.

Sincerely,

Practitioner's Name

Facsimile Cover Sheet

Date: _____ Time: _____

To: _____ From: _____

Total number of pages (including this page): _____

If you do not receive all pages or if the transmission is unclear, please call:

(xxx) xxx-xxxx office number (9:00 a.m. to 5:00 p.m.)
(xxx) xxx-xxxx fax number (9:00 a.m. to 5:00 p.m.)

This message is intended only for the use of the individual(s) or entity to which it is addressed and may contain information that is privileged, confidential, and/or exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disseminating, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone, and return the original message to *Practitioner's Name & Address,* via the US Postal Service.

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

Practitioner's Name

Practitioner's Address & Phone Number

Telephone Contact Record

Date: _____

Name of Person Contacted: _____

How Contact Initiated: _____

Home Phone: _____ Work Phone: _____

Best Days/Times to Call: _____

1. Reason For Contact: _____

   _____ Counseling For Self/Couple
   _____ Family Counseling
   _____ Workshops
   _____ Counseling For Child
   _____ Group Counseling
   _____ Other: _____

2. Referral (if applicable): _____

   _____ Family Member
   _____ Physician
   _____ School Personnel: _____
   _____ Other: _____
   _____ Friend
   _____ Therapist: _____
   _____ Managed Care: _____

3. Are You Responding to an Ad? _____ Yes _____ No

   If yes, where was ad seen?: _____

4. Relevant Additional Information: _____

   _____

5. Follow-up Required: _____ Yes _____ No

   If so, when & by whom?: _____

Borrowing Agreement

Item Borrowed: _____

Date Borrowed: _____

Date Due: _____

Replacement Cost: _____

I agree to the following terms:

1. Items borrowed are due for return one week from date borrowed.
2. If not returned in two weeks, I agree to pay *Practitioner's Name* the cost of replacing the borrowed item.

_____

Signature

(Sample)

Materials Available (for borrowing)

AUDIO TAPES

Replacement Cost Charged

Being Yourself by Carl Rogers

$10 *Tape 1:* "What Are the Goals of Life & What It Means to Be Married"

$10 *Tape 2:* "Is It Possible to Be Yourself & the Struggle to Become a Person"

$10 *Tape 3:* "Sharing Something of Yourself & the Place of Feelings & Emotions"

$10 *Tape 4:* "Relationships with Our Children & the Lonely Person"

$12 *But Mom, It Wasn't Me! Honest!* (about lying)

$15 *Coping With Anxiety* by Rollo May (for adults)

$10 *Criticism*

$10 *How to Talk So Kids Will Listen . . . And Listen So Kids Will Talk* by Adele Faber

$10 *Loving Your Children Is Not Enough—Positive Discipline That Works*

BOOKS

Replacement Cost Charged

$10 *Children & Grief*

$12 *The Grieving Child* (for adults)

$14 *He Hit Me First* (sibling rivalry) by Louise Bates Ames

$13 *Healing the Child Within* by Charles Whitfield (for adults)

(may not take home)
Helping Children Grow Up in the '90s (short articles on many topics—may ask for copies of up to 3 articles per week) by National Association of School Psychologists

$12 *Instead of Therapy* by Dr. Tom Rusk (for adults)

(may not take home)
Kid Tricks—Helpful Hints for Working with Children (activity & game ideas)

$7 *Parenting: A Skills Training Manual* by Dr. Louise Guerney

$7 *Play Therapy* by Virginia Axline

$30 *Safety for Families with School-Aged Children*

$15 *Sharing the Children* (custody arrangement) by Robert Adler, Ph.D. (for parents)

GAMES

Replacement Cost Charged

$15 Ungame (couples version)

◆ CHAPTER TWO ◆

Billing (Insurance and Self-Pay)

This section includes forms, posting sheets, and references regarding billing for both insurance covered and self-pay clients.

The following items are included:

- Sample Client Posting Sheet
- Commonly Used CPT Billing Codes
- Sample Bill for Services Form
- Sample Monthly Billing Statement
- Sample Insurance Billing Form (HCFA)
- Insurance Verification Sheet
- Overdue Payment Notice

For additional information, please see the Managed Care section of this book.

Client Posting Sheet

The following form is used to keep a daily log of clients seen and services rendered. The procedure/diagnosis column may be used for CPT, ICD-9, and/or DSM codes. The "method" column is used to indicate from where payments came. I use "S" for self-pay and "INS" for insurance payments.

(Sample Client Posting Sheet)

Provider Name: Calendar Year:

Date	Client Name	Procedure Code	Charge	Waiver/ Write-off	Payment	Method

Billing Codes

The following three pages provide a listing of CPT (Current Procedural Terminology) billing codes most frequently used in my practice. Some insurance companies now require codes as appearing in the ICD-9 (International Classification of Diseases) directory. There are some reference materials designed to assist in converting codes from CPT to ICD-9. If this is an issue for you, I suggest contacting a local billing service for suggestions on code conversion resources, or call Medical Arts Press at (800) 328-2179. In addition to standard CPT codes, two "personal" codes (99011, 90012) are included which will help assist you in tracking canceled and missed appointments.

Commonly Used CPT Billing Codes

90804 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.

90805 with medical evaluation and management services.

90806 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.

90807 with medical evaluation and management services.

90808 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient.

90809 with medical evaluation and management services.

90846 Family medical psychotherapy (without the patient present).

90847 Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated.

90853 Group medical psychotherapy (other than of a multiple-family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated.

90882 Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.

90887 Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient.

90889 Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

90899 Unlisted psychiatric service or procedure.

99011 Missed appointment.

99012 Canceled appointment with notice.

99050 Services requested after hours in addition to basic service.

99052 Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service.

99054 Services requested on Sundays and holidays in addition to basic service.

99056 Services provided at request of patient in a location other than physician's office which are normally provided in this office.

99058 Office services provided on an emergency basis.

99070 Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided).

99071 Education supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician.

99075 Medical testimony.

99078 Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions).

99080 Special reports such as insurance forms, or the review of medical data to clarify a patient's status—more than the information conveyed in the usual medical communications or standard reporting form.

99082 Unusual travel (e.g., transportation and escort of patient).

99199 Unlisted special service or report.

99352 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

99353 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies and provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem.

99361 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes.

99362 Approximately 60 minutes.

99371 Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (e.g., to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy).

99372 Intermediate (e.g., to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate

medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care).

99373 Complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan).

Bill for Services

This form is one I use most frequently for billing organizations to whom I have provided services. It is an easy to use, easy to follow up form which allows you to keep a record of charges not normally kept on monthly billing statements. Use for consults, off-site services, services to schools, agencies, government programs, etc.

(Sample Bill for Services)

Practitioner's Name
Practitioner's Address & Phone Number

Bill for Services

Date: _____ BILL #: _____

Bill To: _____
_____
_____
_____

Date	Service Provided	Billed Time	Hourly Rate	Charge
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Total Due: _____

Please Remit By: _____

(Sample Monthly Billing Statement)

Practitioner's Name
Address
Phone Number

Statement

Account No.: _____ Page _____

Charges or payments after
billing date _____
will appear on next statement

$_____
Amount Enclosed

John Q. Client
Anywhere Way
Hometown, State, Zip

ALL CHARGES ON THIS STATEMENT DUE ON PRESENTATION. PLEASE RETURN THIS PORTION OF STATEMENT WITH PAYMENT.

****

PLEASE RETAIN THIS PORTION OF STATEMENT FOR YOUR RECORDS

Date	Description	Reference	Charges	Credits
01-31-XX	Balance Forward Client, John		30.00	
02-01-XX	Family Psych w/o Client	960201	65.00	
02-06-XX	Payment Thank You	960201		−25.00
02-02-XX	Phone Call	960202	32.50	
02-02-XX	Waiver Regular Fee	960202		−32.50
02-06-XX	45 to 50 Min Psychotherapy	960206	65.00	
02-06-XX	Payment Thank You	960206		−25.00
02-09-XX	Intervention With Agencies	960209	97.50	
02-14-XX	45 to 50 Min Psychotherapy	960214	65.00	
02-28-XX	45 to 50 Min Psychotherapy	960228	65.00	
02-28-XX	Payment Thank You	960228		−25.00

Current	30 Days	60 Days	90 Days	Total Detail	282.50	Balance Due
				Past Due	0.00	
312.50	0.00	0.00	0.00	Total Balance	312.50	312.50

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [X] FECA BLK LUNG [ ] OTHER [ ]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, James E.

3. PATIENT'S BIRTH DATE: 03 15 85 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Smith, Rebecca H.

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Main Street

CITY: Vancouver STATE: WA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Vancouver STATE: WA

ZIP CODE: 98660 TELEPHONE (Include Area Code): (360) 123-4567

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 98660 TELEPHONE (Include Area Code): (360) 123-4567

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [X]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ABC Insurance Group

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File DATE: 05-01-XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature On File

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)

1. 300.4
2. 313.81
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 16 XX	03 16 XX	11	9	90801		12	65.00					
2 03 23 XX	03 23 XX	11	9	90806		12	65.00					
3 03 30 XX	03 30 XX	11	9	90806		12	65.00					
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 987654321 SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.: Smith011

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 195.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 195.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Practitioner's Name

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Practitioner's Name & Address

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Insurance Verification Sheet

This sheet is used to keep track of information obtained pertaining to a client or prospective client's insurance coverage. It is a convenient form easily used and easily referenced if needed at a later date. I recommend keeping completed forms in the corresponding case files.

Insurance Verification Sheet

Patient's Name: _____

Address: _____

Insurance Company: _____

Address: _____

Phone: _____

Insured: _____

Social Security #: _____

Policy #: _____

Group #: _____

Deductible: _____

Deductible Met?: _____

Max. Dollar Benefit: _____

Max. Number of Sessions: _____

Percentage Paid By Insurer: _____

Verified By: _____

Date Verified: _____

Initials: _____

Notes:

Overdue Payment Notice

Date: _____

Client Name: _____

Responsible Party: _____

_____

_____

Date of Service: _____

Payment Due: _____

Amount Received To Date: _____

Payment Past Due: _____

Please remit the above indicated amount past due within 10 days of the date of this notice. If payment has been sent, please disregard this notice.

Thank you.

Practitioner's Name

◆ CHAPTER THREE ◆

Client Release and Consent Forms

This section contains some of the most common types of release and consent forms. It is intended to serve as a frame of reference from which to construct your forms. It is essential in preparing forms that you be aware of the laws regarding consent in your state.

The following sample forms are included in this section:

- Authorization to Release Mental Health Care Information
- Response to Request for Information
- Release Form—Minor's Consent Required
- Consent for Use of Picture and/or Voice
- Permission for Treatment at Outside Facility

Authorization to Release Mental Health Care Information

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____

I request and authorize the mutual release of health care information of the patient named above between:

Practitioner's Name
Practitioner's Address
Practitioner's Phone Number

and

Name: _____
Address: _____
_____
_____

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition or dates of treatment: _____
_____

_____ All health care information

_____ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER THE DATE IT IS SIGNED AND MAY BE REVOKED AT ANY TIME UPON WRITTEN REQUEST OF THE CLIENT EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN.

_____
Signature of patient or patient's authorized representative Date signed

_____
Relationship or status if signed by anyone other than patient (parents, etc.)

Practitioner's Name
Practitioner's Address & Phone Number

Response to Request for Information

Date: _____

To: _____

Re: _____

From: *Practitioner's Name*

You recently requested information regarding the individual(s) named above.

_____ The requested information is enclosed. You may not release this material to any other party without express written consent.

_____ I am unable to send the requested information for the following reason(s):

_____ I have no record of having provided service to this person/family. Is it possible this patient might be known by a different name?

_____ You did not send a properly executed release. Enclosed please find a release form to be signed by:

_____ Patient

_____ Patient's Parent(s) or Guardian

_____ Other _____

If you have any questions or need additional information, please let me know.

Practitioner's Name
Practitioner's Address & Phone Number

Practitioner's Name
Practitioner's Address & Phone Number

Release Form—Minor's Consent Required

To Whom It May Concern:

I, _____, Date of Birth _____, Social Security # _____, hereby authorize any mental health facility, counseling center, physician, psychiatrist, psychologist, or counselor to disclose, when requested to do so by *practitioner*, any and all information concerning myself with respect to any illness or injury, medical history, consultation, prescription or treatment, and copies of any medical, or social service records.

A photostatic copy of this-authorization shall be considered as effective and valid as the original.

_____
Signature

_____
Date

Note: ***The age requirement for this release form varies by state. Check your state regulations for further information.***

Practitioner's Name
Practitioner's Address & Phone Number

Consent for Use of Picture and/or Voice

Client Name: _____

I hereby voluntarily and without compensation authorize pictures and/or voice recording(s) to be made of me (or of the above-named individual if individual is legally unable to give consent) during counseling sessions with *Practitioner's Name*.

I understand that the said picture(s) and/or voice recording(s) is/are intended for the following purpose(s):

_____

_____

I have read and understand the foregoing and I consent to the use of my picture and/or voice as specified for the above-described purpose(s).

_____ _____

(Signature of individual or other legally authorized person) (Date)

Practitioner's Name
Practitioner's Address & Phone Number

Permission for Treatment at Outside Facility

I _____ give my consent for _____
(parent/guardian) *(provider)*

to treat _____ at _____
(patient) *(facility)*

_____ _____
Signature Date

◆ CHAPTER FOUR ◆

Intake, Clinical Evaluation, and Progress Monitoring

This section is designed to assist you with materials for use with new clients, as well as for tracking progress of existing clients.

The following items are included:

- Client Information—Adult
- Client Information—Minor
- Fee Agreement
- Disclosure Statement
- Sample Group Fee Agreement
- Sample Counseling Philosophy Statement
- Diagnostic and Treatment Evaluation Form
- Psychotherapy Progress Note
- Client Worksheet
- Written Counseling Materials Checklists

For your convenience, I recommend putting together intake packages to give to new clients consisting of a Client Information Form, Fee Agreement (client & office copies), Disclosure Statement (client and office copies), any other legally required forms or information (varies by state), and any other materials you decide to include.

Practitioner's Name
Practitioner's Address & Phone Number

Client Information—Adult

To help me with our first session, please fill out the following information as completely as possible:

Date: _____

Name: _____
First Middle Initial Last

Address: _____
Street City State Zip Code

Date of Birth: _____ Age: _____
Place of Birth: _____
Phone: (H) _____ (W) _____ (other) _____
Social Security No.: _____
May you be contacted at work?: _____
Marital Status:
Single _____ Married _____ Separated _____ Divorced _____
If married, spouse's name: _____
Age: _____ Place of employment: _____
Number of years married: _____
If divorced, ex-spouse's name: _____
Age: _____ Number of years divorced: _____
Children:
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Employment (job title): _____
Place: _____

Family Physician:
Name: _____
Address: _____

Are you taking any prescription drugs at this time?: Yes: _____ No: _____
If yes, what type and for what purpose?: _____

Referral Source: _____

Insurance Information:

Company: _____

Address: _____

Phone: _____ ID No.: _____

Group: _____ Insured: _____

Have you ever attempted to commit suicide? Yes _____ No _____

If yes, please describe: _____

_____

Have you ever had counseling before? Yes _____ No _____

If yes, please describe and list name of person(s): _____

_____

Please make note of any other comments that you feel are important to this counseling process:

_____

_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize *Practitioner* to:

1. Furnish my insurance company with any/all information requested concerning my present claim(s).
2. Bill my insurance company and accept payment from that company on my behalf for all services from time to time relating to my care.

I acknowledge that I am responsible for all charges not covered by my insurance.

NOTICE OF INFORMATION PRACTICES

NOTICE: I keep a dated record of the services I provide you. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your records to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it from my office staff. The fees for copying records, searching for records or editing records are as follows:

Copying	$.65 per page for first 30 pages $.50 for each additional page
Searching	$15.00 per search
Editing by the therapist personally when required by statute	Basic office visit charge

All copies will be released only upon receipt of payment.

_____

Client's Signature Date

Practitioner's Name

Practitioner's Address & Phone Number

Client Information—Minor

Please note!! The parent bringing a minor child to the appointment is the responsible party regardless of who carries the insurance. Please complete form accordingly.

Today's Date: _____

Client's Full Name: _____

D.O.B.: _____

Address: _____ City: _____

State: _____ Zip: _____

Phone: _____ Length at Present Address: _____

****

I will be paying today by check or cash (please circle one).

Responsible Party**: _____

Phone: _____ D.O.B.: _____

Address: _____ City: _____

State: _____ Zip: _____

SS #: _____ Employer: _____

Emp. Address: _____ Phone: _____

Spouse of responsible party: _____ D.O.B.: _____

SS#: _____ Employer: _____

Emp. Address: _____ Phone: _____

****

Person to Contact in Case of Emergency: _____

Home Phone: _____ Work Phone: _____

Client's Physician: _____ Date of Last Exam: _____

Reason for Referral: _____ Referred By: _____

Previous Therapy?: _____ With Whom?: _____

Insurance information (if applicable)

Company: _____

Address: _____

_____

Phone: _____

ID #: _____

Group: _____

Insured: _____

****

Authorization to release information and assignment of insurance benefits.

I hereby authorize *Practitioner* to:

1) Furnish my insurance company with any/all information requested concerning my present claim(s).
2) Bill my insurance company and accept payment from that company on my behalf for all services from time to time relating to my care.

I acknowledge that I am responsible for all charges not covered by my insurance. I agree that if costs or fees are incurred in connection with the collection of this account, I will pay all such costs and fees, including, but not limited to, collection costs, attorney's fees, and all court costs. I understand that failure to resolve any outstanding balance may result in any account being referred to a collection agency if it remains delinquent without a response from me.

Notice of Information Practices

Notice: I keep a record of the services I provide you. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it from our office staff. The fees for copying records, searching for records, or editing records are as follows:

Copying:	$.65 per page for the first 30 pages $.50 per page thereafter
Searching:	$15 per search
Editing (by the therapist personally when required by statute)	Basic office visit charge

All copies will be released only upon receipt of payment.

_____ _____

Responsible Party's Signature Date

Fee Agreement and Disclosure Statement

These forms are an important part of the intake package. They need to be clear and concise, conveying information in easy to understand terms. Avoid use of technical terms and jargon whenever possible, and explain any technical language used. I recommend having two copies of each form in the intake package, one "office copy" and one "client copy."

Practitioner's Name
Practitioner's Address & Phone Number

Fee Agreement

*** * PLEASE READ BOTH SIDES OF THIS DOCUMENT THOROUGHLY * ***
*** * BEFORE SIGNING * ***

I, _____ , agree to pay a fee of _____ to (Practitioner's Name) for each 45-50 minute counseling/therapy session held or not canceled with notice as stated on the reverse of this agreement form. I also agree to the fee schedule for additional services as stated below. I HAVE READ AND UNDERSTAND THESE OFFICE AND FINANCIAL POLICIES, AND AGREE TO THOSE TERMS.

Fee Schedule

Report/Letter Preparation	**$72/hr.**
Telephone Calls/Consults with Client/ Parent(s) Exceeding 10 Minutes in Length	**$72/hr.**
Consultation with Other Professionals (lawyers, doctors, therapists, etc.) as Requested and/or Approved by Client/Parent(s)	**$72/hr. (including travel time if not by telephone)**
Home Visits	**$72/hr. (including travel time)**
Court Testimony (including preparation time, travel, reports, waiting, and testimony)	**$140/hr.**

Client's Signature (responsible party's signature if client is a minor):

_____

Effective date: _____

Financial Policy

Thank you for choosing me as your health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of my Financial Policy which I require you read and sign prior to any treatment. **Please ask any questions you may have before signing this agreement.**

Clients must complete all required forms before seeing (Practitioner's Name).

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. I ACCEPT CASH OR CHECKS ONLY. IF YOU ARE ON A *MANAGED CARE PLAN* CO-PAYMENTS (IF ANY) ARE DUE AT THE TIME OF SERVICE.

Regarding Insurance:

I am able to provide you with a receipt appropriate for submission to your insurance carrier for each visit/service. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. I am not a party to that contract. I do not guarantee payment from your insurance company. If your insurance company has not paid your account in full within 90 days, the balance will be automatically due and payable by you. Please be aware that some, and perhaps all of the services provided may be non-covered services or may not be considered to be reasonable and/or necessary under your medical insurance program. I do not bill third parties.

ALL ACCOUNTS OVER 90 DAYS ARE CHARGED INTEREST AT THE LEGAL RATE OF 1&1/2% PER MONTH ON THE UNPAID BALANCE WITH A MINIMUM CHARGE OF $.50 REGARDLESS OF WHETHER INSURANCE IS PENDING OR NOT.

Missed Appointments:

Unless canceled 24 hours in advance, my policy is to charge for missed appointments at the rate of a normal office visit. I have a 24-hour voice mail service for your convenience. Emergency cancellations (less than 24 hours) are handled on an individual basis.

ALL RETURNED CHECKS ARE SUBJECT TO A FEE OF $20.00

(Sample Disclosure Statement)

Washington State Registration #AB00000000

Disclosure Statement

Thank you for considering my counseling services. In order to help you make an informed decision, I have prepared this statement for you to read. Please review this statement in its entirety and sign it in the space provided. If you have any questions or concerns, I would be pleased to discuss them with you.

Types of Counseling Provided

The types of counseling services I provide are generally directed toward children, adolescents, and families. Issues such as self-esteem, behavioral difficulties in school and/or home, divorce or separation, bereavement, and difficulties in family communication are among the range of situations with which I typically work. I also provide counseling services to adults, both in an individual or couples format. Individual counseling is my most frequently used modality, with group counseling being provided or offered as warranted.

Education, Training, and Experience

My highest degree is an M.A. in Psychology from Sonoma State University in Rohnert Park, California. The bulk of my education prior to that was taken in the upstate New York area, where I am from originally. I have also had additional graduate-level training in Counseling and Human Development from Penn State University. My work at Penn State included training in play therapy, a technique I practice frequently with younger children.

I have been working with children and families in various capacities since 1983. I have served as a counselor/therapist for public and private sector organizations, and have worked for schools, non-profit agencies, government-sponsored programs, and an adoption service. My work has also included coordinating programs designed to provide services to multi-cultural and economically disadvantaged youth. I believe that my diversity of experiences has provided me with a range of skills and an ability to flexibly approach each client's unique circumstances.

Methods of Counseling

My approach to counseling is interactive in style and based on the empathic response model, which emphasizes the importance of understanding and coming to terms with feelings. My philosophy of counseling is based on the belief that the client possesses the power to change, and that it is my role to help the client become aware of how to understand and utilize that power. This is a philosophy of empowerment—it accepts the client as the driving force in change. I believe this approach brings about effective long-term results, for the reason that the client discovers how to utilize his/her own inner strengths and gifts rather than having to rely on someone else for solutions to life's difficult issues. For a more detailed description of how this approach is applied to children's counseling, please ask for my handout on play therapy.

Counselor Credentialing Act

Washington State law requires my informing you of the Counselor Credentialing Act, which has been designed to "protect the public health and safety," and "to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct." The law also requires the following statement:

> "counselors practicing counseling for a fee must be registered or certified with the department of licensing for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment."

If you should have questions or concerns, please do not hesitate to bring them up. My goal is to have counseling be a positive, productive part of my clients' lives. I will give my utmost effort to help accomplish this goal.

I have read this disclosure statement and understand its content. I also acknowledge receiving a copy of this statement. I have been provided with a fee agreement stating the agreed cost of counseling sessions and policies regarding payments.

Signature: _____
(responsible party if client is a minor)

Date: _____

Counselor's Signature: _____

Date: _____

(Sample Group Fee Agreement)

Parenting under Stress

Group Fee Agreement

Start Date: Wednesday, December 7, 20XX

I understand that this group is a 20-week commitment and that I am responsible for payment for each session held, regardless of attendance (emergencies considered on a case by case basis). I understand that my total fee for the group sessions is $300, payable at $15 per week. I also understand that I may withdraw from the group at any time during the first five weeks, with payment owed only for the number of sessions held. As of week six, I am responsible for the entire $300 fee regardless of attendance.

_____ _____

Signature Date

(Sample Counseling Philosophy Statement)

Child Counseling/Play Therapy

I have been working with children in a variety of capacities for the past several years. My background includes work in public and private counseling agencies, school-based intervention programs, and adoption services. My approach to child counseling is based on the empathic response method, which encourages an unconditional acceptance and positive regard for the client. I believe that helping children develop a strong sense of self is essential, and I attempt to accomplish this through both conversation and play.

My work with children is most often conducted in a therapeutic playroom, where the children are given the opportunity to choose their method of expression. The room is equipped with art supplies, dolls, games, and toys which are found to be helpful to a child's self-expression. As time passes, children develop a sense of trust and comfort in the playroom that allows for a sharing of thoughts and feelings. Patience, understanding, and acceptance are key elements of my philosophy and an integral part of my work with children.

Diagnostic and Treatment Evaluation, Progress Note, Client Goal Identification Worksheet, and Written Counseling Materials Checklists

These forms are designed to be used after the initial session with a client, as a method of monitoring progress, and as an update every several weeks, at your discretion. They may also be valuable tools for completing insurance company and managed care reports.

- The *Diagnostic and Treatment Evaluation* form is intended for use in initial intakes, occasional follow-ups, and after closing a case. It is a way of combining clinical diagnostic information with treatment plan and narrative interpretations.

- The *Psychotherapy Progress Note* may be used as a session by session tracking and monitoring of a client's condition.

- The *Client Goal Identification Worksheet* is intended for use in helping the client clarify reasons for being in therapy and outcomes expected or anticipated. It is best used within the first two-three sessions, or if therapy is "stuck."

- The *Written Counseling Materials Checklists* are a way of maintaining a record of any testing materials, handouts, worksheets, etc. utilized as part of the therapy process. Adapt as per materials you might use.

Diagnostic and Treatment Evaluation

Indicate Type: Initial ☐ Follow-up ☐ Ongoing ☐ Closing ☐

Client Name: _____ Date of Birth: _____

Number of Sessions to Date: _____ Today's Date: _____

Clinical Information

Current Problem Rating Scale:

Problem	Not An Issue	Mild	Moderate	Severe
Appetite Disruption	☐	☐	☐	☐
Bizarre Ideation	☐	☐	☐	☐
Conduct Issues	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Gender Identity Issues	☐	☐	☐	☐
Homicidal Ideation	☐	☐	☐	☐
Impaired Memory	☐	☐	☐	☐
Interpersonal Skills Problems	☐	☐	☐	☐
Lack of Impulse Control	☐	☐	☐	☐
Lack of Self-Esteem	☐	☐	☐	☐
Obsessive-Compulsive	☐	☐	☐	☐

Problem	Not An Issue	Mild	Moderate	Severe
Panic Attacks	☐	☐	☐	☐
Paranoia/Ideational	☐	☐	☐	☐
Phobic Issues	☐	☐	☐	☐
Physical Symptoms (somatization)	☐	☐	☐	☐
Self-Injurious Behavior	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐
Suicidal Ideation	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐
_____				
_____				

Current Medications Information

Describe any medications client is currently taking, including type, dosage, and prescribing physician: _____

_____

_____

Axes Diagnostic Assessment

Axis I: _____

Axis II: _____

Axis III (Physical Disorders/conditions): _____

Axis IV: _____

Axis V: Current _____ Highest in Past Year _____

Practitioner's Name

Practitioner's Address & Phone Number

Treatment Information

Treatment Level Recommendations

Type of Treatment	*Frequency*	*With Whom*
☐ Individual Therapy/Counseling	_____	_____
☐ Family Counseling	_____	_____
☐ Group Counseling	_____	_____
☐ Psychological Testing Referral	_____	_____
☐ Self-Help (Specify: _____ _____)	_____	_____
☐ Medication Evaluation	_____	_____
☐ Substance Abuse Treatment	_____	_____
☐ Hospitalization Evaluation	_____	_____
☐ Other (Specify: _____ _____)	_____ _____	_____ _____

Treatment Goals

	New/Previously Stated Goal	Intervention(s) Utilized	Progress Rating (1-10 scale)
1.	_____	_____	_____
	_____	_____	_____
2.	_____	_____	_____
	_____	_____	_____
3.	_____	_____	_____
	_____	_____	_____
4.	_____	_____	_____
	_____	_____	_____
5.	_____	_____	_____
	_____	_____	_____

Narrative (Any further description of and/or information regarding this case of particular relevance)

_____

_____

_____

_____

Practitioner's Name

Practitioner's Address & Phone Number

Psychotherapy Progress Note

Clinician: _____ ☐90801 ☐90804 ☐90805 ☐Other:
☐90806 ☐90847 ☐90880 _____

Client Name: _____

Diagnosis: _____

Session Date: _____ Duration: _____ (Minutes)

Current Treatment Plan: Seen _____ per _____ week(s)

Current Subjective Concerns:

_____

_____

Current Observations:

Progress: ☐Crisis ☐Fragile ☐Stable ☐Changes
Affect: ☐Bright ☐Manic ☐Angry ☐Anxious ☐Depressed ☐Flat ☐Other
Presentation: ☐Well-Groomed ☐Casual ☐Disheveled ☐Other

Therapeutic Goals Addressed (check all as applicable)

- ☐Interpersonal Problems
  - ☐Spouse
  - ☐Parent(s)
  - ☐Children/Sibling(s)
  - ☐Teacher(s)
  - ☐Peer(s)
  - ☐Supervisor(s)
- ☐Coping Strategies
  - ☐Home
  - ☐School
  - ☐Work
  - ☐Parenting
- ☐Skill Building
  - ☐Organizational Skills
  - ☐Interpersonal Skills
    - ☐Anger Mgmt./Frustration Tolerance
  - ☐Impulse Control
  - ☐ADLs
  - ☐Healthcare Management
- ☐Behavior Modification
  - ☐Inappropriate Behaviors
  - ☐Fear/Phobia
- ☐Emotional Distress
- ☐Self Perception/Self Efficacy
- ☐Insight Orientation

Intervention Employed: (check all as applicable)

☐Cognitive Therapy ☐Problem Solving ☐Existential
☐Psychodynamic ☐Hypnosis ☐Play Therapy
☐Client Centered ☐Psychoeducation ☐Behavioral
☐Other: _____

Outcome of Session: _____

_____

Plan: _____

_____

_____

Clinician Signature Date

Practitioner's Name
Practitioner's Address & Phone Number

Client Goal Identification Worksheet

Name: _____ Therapist: _____ Date: _____

My major difficulties are:

1. _____
2. _____
3. _____
4. _____
5. _____

Needs:

A. I feel genuinely loved by someone other than my parents or my children:

0 / / / / / / / / / / /

not at all very much

B. I feel in control of my life situation:

0 / / / / / / / / / / /

not at all very much

C. I feel worthwhile:

0 / / / / / / / / / / /

not at all very much

D. I have fun:

0 / / / / / / / / / / /

not at all very much

Goals:

I would like to change my life by behaving differently in the following specific ways:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Hope:

I predict I will accomplish *my* goals listed above:

A. Totally
B. Mostly
C. Partially
D. Not at all

Practitioner's Name
Practitioner's Address & Phone Number

Client Name: _____

Written Counseling Materials Checklist—Children

Item		Date(s) Used
☐	World Test	_____
☐	Sentence Completion	_____
☐	Common Inventories:	
	☐ Coopersmith	_____
	☐ STAI-C	_____
☐	Oppositional Behavior Checklist	_____
☐	Making or Losing Friends Form	_____
☐	Social Skills Worksheets	_____
☐	Controlling Temper Worksheets	_____
☐	Conflict Worksheets	_____
☐	Divorce Diary	_____
☐	Other:	
	_____	_____
	_____	_____
	_____	_____

Parents:

☐	Auchenbach Checklist	_____
☐	Child Behavior Rating Scale	_____
☐	Parenting Stress Index	_____
☐	STAI-Y	_____
☐	Other:	
	_____	_____
	_____	_____
	_____	_____

Practitioner's Name
Practitioner's Address & Phone Number

Client Name: _____

Written Counseling Materials Checklist—Adolescents

Item		Date(s) Used
☐	Client Worksheet	_____
☐	Sentence Completion	_____
☐	World Test	_____
☐	Oppositional Behavior Checklist	_____
☐	Values Survey	_____
☐	STAI-Y (16+)	_____
☐	Changepoint Workbook	_____
☐	Assertiveness Handout	_____
☐	Social Skills Worksheets	_____
☐	Other:	
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Parents:

☐	Auchenbach Checklist	_____
☐	Parenting Stress Index	_____
☐	STAI-Y	_____
☐	Other:	
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Practitioner's Name
Practitioner's Address & Phone Number

Client Name: _____

Written Counseling Materials Checklist—Adults

Item		Date(s) Used
☐	Client Worksheet	_____
☐	STAI-Y	_____
☐	Marital Satisfaction Inventory	_____
☐	MMPI	_____
☐	Parenting Stress Index	_____
☐	My Vocational Situation	_____
☐	Problem Behavior Inventory	_____
☐	Logical Reasoning Test	_____
☐	Life Performance Inventory	_____
☐	Self-Empowerment Process	_____
☐	Self-Esteem Handouts:	
	_____	_____
	_____	_____
	_____	_____
	_____	_____

◆ CHAPTER FIVE ◆

Marketing

This section includes the following sample advertisements, letters, announcements, and forms pertaining to development of your practice:

- Letter of Introduction
- Follow-Up Letter
- Time-Saving, Practical Lists to Develop and Maintain
- Brochures
- Print Ads
- Press Release
- Group Interest Questionnaire
- Group Assessment Form
- Community Education Announcement
- Parenting Group Announcement (Ongoing)
- Children's Group Announcements
- Workshop Announcement

These samples are intended to serve as guidelines in your development of a marketing strategy. Use them as the basis upon which to create useful marketing tools. Be sure to focus on your areas of specialization when adapting these samples.

Letter of Introduction and Follow-Up

These letters are used to introduce yourself to other professionals in your area, and to maintain contact with prior referral sources. Be sure to include your brochures and/or business cards with your letter. Examples of where to send these letters in your area include:

- Other mental health professionals
- School personnel
- Corporate human resources or benefits administrators' offices
- Government mental health agencies
- Doctors/Health Care Offices
- Attorneys

(Sample Letter of Introduction)

Practitioner's Name
Practitioner's Address & Phone Number

Date

Hello:

I am a counselor/therapist in a downtown Vancouver private practice writing to request your consideration for possible referrals. Enclosed you will find some descriptive materials regarding my background as well as business cards and coupons for complimentary consultations. I specialize in work with children, families, and adult relationship issues, and provide individual as well as family and group therapy. A play therapy room is on site, and is frequently utilized with children and families.

As a certified counselor in the state of Washington, I am eligible for third-party reimbursements from a number of insurance carriers and governmental programs. I am a provider for the Crime Victims Compensation Program in Washington, and am able to assist persons from the application process through therapy services. I am also a provider for several managed care companies, including ABC Behavioral Health and XYZ Behavioral Health. I have some limited-income, low fee slots available, and can assist in providing referrals to funding sources when appropriate. Group therapy is often a cost-effective alternative for treatment—interested parties should call regarding ongoing or newly forming groups.

I would be pleased to meet with you at your convenience should you wish, and invite your call to make arrangements for a visit to my office or vice-versa. Please feel free to contact the references I have included, and to call if you require additional ones. I look forward to hearing from you, and thank you for your consideration.

Sincerely,

Practitioner's Name

Enclosures

02

(Sample Follow-Up Letter)

Practitioner's Name
Practitioner's Address & Phone Number

Date

Dear Friends & Colleagues:

I have appreciated your referrals to my private counseling practice over the past few years, and am writing to provide you with some updated descriptive materials. As you know, I specialize in working with children, adolescents, and families, as well with adults needing help with relationship issues. I continue to have a play therapy room on site, and have recently improved the scope of materials available.

As a certified counselor in the state of Washington, I am eligible for third-party reimbursements from a number of insurance carriers and governmental programs. I am a provider for the Crime Victims Compensation Program in Washington, and am able to assist persons from the application process through therapy services. I am also a provider for several managed care companies, including ABC Behavioral Health and XYZ Behavioral Health. I have some limited-income, low fee slots available, and can assist in providing referrals to funding sources when appropriate. Group therapy is often a cost-effective alternative for treatment—interested parties should call regarding ongoing or newly forming groups.

I have been pleased to work with you in the past, and look forward to doing so on an ongoing basis. Please feel free to call at your convenience—I would be pleased to arrange a visit to your location or mine. If you need additional copies of any materials, please let me know.

Sincerely,

Practitioner's Name

Enclosures

Time Saving, Practical Lists to Develop and Maintain

Community Resources List—this would include other professionals to whom you refer, agencies providing services which might be of use to your clients, crisis intervention services, physicians, government agencies with which you and your clients may deal, and any other resource you would like to be able to access in your community.

Suggested format:

Name of Organization Service(s) Provided Address and/or Phone Fax/E-mail

Mailing List—this list would be used in marketing your practice, and might consist of current and former clients, other professionals in the community, area hospitals, schools, churches, agencies, etc., which might help you generate and maintain effective business relationships.

Referral Network List—as you begin and continue to make yourself known in your community, you most likely would like to keep a list of those from whom you have received referrals and to whom you will make referrals. This list could well be one of your most important resources, and should be updated regularly.

Testing Materials List—keep a written listing of all materials you have available for testing and evaluating clients. This will provide you with a quick, handy reference when the need for testing arises.

Suggested format:

Name of Test/Profile Purpose Ages Cost to Client (if any)

Brochures

The following are two examples of practice brochures, one generally describing my practice, and the other focusing on Workshops, Seminars, and Classes. They are laid out in a tri-fold brochure format. I find that use of specialty papers and logos can help create an appealing, eye-catching result. The information in your brochures will be of no use if it is not read, so try to prepare a product that will bring attention to itself.

Please feel free to call with any questions you may have concerning counseling with me. I would be pleased to try to help as best I can. My commitment is for counseling to be a positive, productive part of your life. I will do my utmost to help accomplish this goal.

06

Mark Vellucci, M.A.
The Arts Building
1104 Main Street, Suite 212
Vancouver, WA 98660

(360) 696-1646

Mark Vellucci, M.A.

Certified Counselor (WA)

Individual, Family, and Group Counseling

Specializing In:

Play Therapy (Ages 4+)
Relationship Issues
Parenting & Family Issues
Stress Management
Personal Growth

(360) 696-1646

07

I am pleased that you are considering counseling services with me. Trying to find the right counselor for you, your child, or your family is often quite difficult and confusing. It is a highly personal decision, and requires serious consideration. The following information is designed to help you know about my practice and what you may expect from counseling with me.

I am a privately practicing counselor, certified to provide services in the state of Washington. My highest degree is an M.A. in Psychology from Sonoma State University in Rohnert Park, California. I am presently a member in good standing of the American Mental Health Counselors Association, Association For Play Therapy, and Association of Humanistic Psychology. In addition to my office practice, I provide services for local school districts and private schools, and also conduct workshops and classes through community education.

Counseling Approach

My approach to counseling is interactive in style and based on the concept that understanding and coming to terms with emotions is essential to effective problem solving and personal growth. I attempt to provide a supportive, non-judgemental environment in which clients will feel comfortable in sharing and exploring their feelings. My goal is to help the client develop long-term skills for coping and prospering. This empowers the individual to deal with life in an effective, personally rewarding way.

Fees

My fee for individual and family counseling is $72 per 45-50 minute session, payable at each visit. I am eligible for third-party reimbursement from many insurers. If you are considering insurance reimbursement and need assistance in determining eligibility, please call my office staff—they will provide you with the help you require. If you are a member of a managed care network in which I participate, you may only be required to provide a co-payment at each visit. I also maintain a limited number of sliding-fee openings for those demonstrating need—please contact me for details.

Groups

Group fees vary, but generally range from $20 to $40 per session. Call for current or upcoming group offerings.

Workshops, Classes, & Seminars

A variety of programs are offered in the areas of parenting skills training, personal growth, and stress management. They are available to schools, community organizations, agencies, or other interested groups. Please call or write for a descriptive brochure regarding these offerings.

Suggestions For Your First Session

- Arrive 15-20 minutes prior to scheduled appointment time to complete paperwork.
- Make a list of items you would like to discuss.
- Feel free to ask questions.
- Use this time to evaluate your comfort level with me.
- Think about what you would like to accomplish as a result of counseling.
- Bring coins for on-street parking meters.

Availability Of Services

Services are available on an hourly rate and/or contract basis. Fees will vary by program length and site of presentation.

Workshops, seminars, and classes can be provided at your site or Mark Vellucci's office location at 1104 Main Street, Suite 212, Vancouver, Washington, 98660.

For further information, please contact Mark Vellucci at:
(360) 696-1646
(360) 571-3981
(360) 696-9729 (fax)

Workshops, seminars, and classes available for corporations, schools, public and private agencies, community organizations, and individuals.

Mark Vellucci, M.A.
1104 Main Street, Suite 212
Vancouver, WA 98660

(360) 696-1646
(360) 571-3981
Fax (360) 696-9729

Workshops, Seminars, and Classes on:

Child and Family Issues, Effective Communication, & Stress Reduction

A Series of Programs Offered By:

Mark Vellucci, M.A.

Certified Mental Health Counselor

(360) 696-1646
(360) 571-3981

Providing

- On-site presentations
- Flexible scheduling
- Custom-designed presentations
- Single day or ongoing sessions
- Follow-up presentations

About The Programs

Workshops, classes, and seminars offered are designed to educate and empower the participants. Utilizing an interactive model, these programs encourage participation and cooperativeness. The results to be expected include:

- A deeper understanding of the issue(s) presented
- A feeling of empowerment through knowledge of self
- Practical application to daily life
- Stress reduction

Workshops typically consist of a 1–3 hour presentation, seminars 4–6 hours, and classes 1–1 1/2 hours for 4–12 weeks.

Programs Available

These are some of the specific topic areas addressed.

Parenting/Family Issue

- **Disciplining Young Children without Screaming**
- **Effective Communication with Children**
- **Parenting under Stress**
- **Emotional Needs of the Gifted Child**
- **Coping with Divorce/Blended Families**
- **Conflict Management**

Personal Growth

- **Communicating for Personal Power**
- **Assertiveness Training**
- **Time Management & Stress Reduction**
- **Getting & Staying Motivated**

School Issues

- **Mental Health Screening Devices in the Schools**
- **Communication: The Empathic Response Method**
- **Classroom Conflict Resolution**
- **Recognizing and Reporting Child Abuse**
- **Child Safety**

Other topic areas are available, and can be developed to suit your organization's needs. Individual, family, and group psychotherapy are also available. Call for details and fees.

Professional Background

Mark Vellucci, M. A., has been working with children and families in several capacities since 1980. His experiences include counseling positions with public and private agencies, multi-cultural enrichment programs, and a supervisory role with a school-based, government-sponsored Primary Intervention Program (PIP).

He has conducted numerous workshops, classes, and seminars for adults and children, both as part of his private therapy practice and for local school districts and community organizations.

He is a certified mental health counselor in the state of Washington, with a Master's Degree in Psychology. His approach emphasizes the importance of recognizing, appropriately expressing, and coping with emotions.

Practitioner's Name
Counselor/Therapist

Child, Adolescent, Adult & Family Counseling
Play Therapy Specialist
Counseling Groups for Children & Parents
Seminars & Workshops for Schools & Community Organizations

For information, or to arrange an appointment, please call:
(Practitioner's Phone Number)

(Practitioner's Address)

Affordable Child, Adolescent, Family, & Adult Counseling

Practitioner's Name
Registered Counselor (state)
Practitioner's Phone Number

- Play Therapy Specialist (Ages 4+)
- Divorce/Separation/Blended Families
- School Problems (behavior, motivation, concentration, social skills)
- Grief & Loss, Depression
- Relationship Enhancement, Personal Growth

* Initial 30-Minute Consult No Charge *
* Conveniently Located at . . . *
* Call for Free Brochure * Uninsured Welcome * Sliding Fees *

Supportive & Empowerjng Counseling for Children, Adolescents, Adults & Families

Practitioner's Name
Registered Counselor (state)

Street Address
City, State, Zip
Phone Number

* Play Therapy Specialist (ages 4+)
* Relationship Enhancement
* Divorce/Separation/ Blended Families
* Parenting Issues
* Grief & Loss, Depression
* School Problems (behavior, motivation, concentration, social skills)
* Personal Growth

Group Counseling for Children—Parent Groups
Initial 30-Minute Consult No Charge—Call for Free Brochure
Uninsured Welcome—Insurance

S A M P L E

P R I N T

A D S

(Sample Press Release)

Practitioner's Name
Practitioner's Address & Phone Number

For Immediate Release

"How to Discipline Young Children without Screaming," a free seminar designed for parents, teachers, and others who are interested in learning how to use a positive approach to child management. The seminar will take place on Wednesday, March 15th, from 4:30–6:00 p.m., at 111 Main Street, Room 303, Springfield.

The workshop, presented by *Practitioner's Name,* will help participants learn to focus on positive child behaviors, examine the function of discipline and how it differs from punishment, and generally feel more effective in their interactions with young children. In order to attend, please reserve space in advance by calling 555-1111 no later than Friday, March 10, 20XX. Seating is limited.

(Sample Group Interest Questionnaire)

Parents' Support Group

I am currently in the process of forming a parents' support group designed to be an ongoing forum for discussion of issues relating to parenting. I anticipate a starting date of mid to late February, with weekly sessions through the balance of the current school year. Among issues to be discussed will be family communication, coping with stresses of raising children, positive reinforcement, structuring of effective limits and consequences, and sibling rivalry. The cost of the group may be eligible for insurance reimbursement for clients whose insurance currently covers my services. My office staff is able to assist in determining insurance eligibility.

I would appreciate your help in completing and returning this questionnaire to me. Thanks for your time.

Name: _____

1. Would you be at all interested in participating in a parents' support group?

   Yes ☐ No ☐

   If yes, please continue.

2. Would you consider a fee of $20-$30 per person per 75-minute session to be reasonable?

   Yes ☐ No ☐

3. Please check as many of the days and times listed below that would be possible for you to attend on a weekly basis:

   Monday: _____ 11:30 a.m. – 12:45 p.m.
   _____ 12:00 noon – 1:15 p.m.
   _____ 12:30 p.m. – 1:45 p.m.
   _____ 1:00 p.m. – 2:15 p.m.
   _____ 1:30 p.m. – 2:45 p.m.

   Wednesday: _____ 1:30 p.m. – 2:45 p.m.

4. Would you be willing to attend a group if people whom you know, or are acquainted with, are participants?

   Yes ☐ No ☐

5. Please list below issues you would like to have discussed that were not mentioned above.

Practitioner's Name
Practitioner's Address & Phone Number

Practitioner's Name
Practitioner's Address & Phone Number

Group Assessment Form

Course/Group Name:

Meeting Day & Time:

Please rate the following by circling the responses that most accurately reflect your opinion.

		Excellent	Very Good	Good	Fair	Poor
1.	Presentation of material	5	4	3	2	1
2.	Preparedness of presenter(s)	5	4	3	2	1
3.	Value of information presented	5	4	3	2	1
4.	Activities & materials utilized	5	4	3	2	1
5.	Overall value of course/group	5	4	3	2	1

6. Please indicate areas you felt were particularly helpful. _____

_____

7. Please indicate areas you felt needed improvement. _____

_____

8. Please indicate any relevant areas not covered that you would like to have had presented.

_____

9. Would you recommend this group/class to friends and/or family? Feel free to elaborate.

_____

_____

_____

10. Other comments. _____

_____

_____

_____

Thank you very much for taking the time to complete this form.

(Sample Community Education Announcement)

Practitioner's Name
Practitioner's Address & Phone Number

Community Education Offerings—Fall 20XX

How to Discipline Children without Screaming

This 2-week class is designed for parents, teachers, and others who are interested in learning how to use a positive approach to child management. Handouts will be presented and reviewed, and time will be made available for question and answer periods.

Date: Tuesdays, September 26 & October 3
Time: 7:00–8:30 p.m.
Fee: $20 per person

Date: Tuesdays, November 28 & December 5
Time: 6:30–8:00 p.m.
Fee: $20 per person

Effective Communication with Children

This workshop will focus on ways to communicate with children that help to encourage cooperation, reduce conflict and increase self-esteem. Feel better about your role as a parent.

Date: Wednesday, October 11
Time: 6:30–8:30 p.m.
Fee: $15 per person

Tips for Single Parents

Assistance for those with one of the most demanding jobs around—single parent. Suggestions on discipline strategies, networking, community resources, and caring for yourself.

Date: Thursday, November 16
Time: 6:30–8:00 p.m.
Fee: $10 per person

In order to register for any of these classes, please consult the County Community Education Booklet or call 555-1234.

All classes to be held at (insert class location, i.e. school name and room number).

Any questions regarding these offerings should be raised with (insert Practitioner's Name) at (insert Practitioner's Phone Number).

(Sample Parenting Group Announcement)

Parenting under Stress:
A Support and Information Group for Parents

Practitioner's Name
Practitioner's Address & Phone Number

This educational and support group is designed for parents with children aged preschool through adolescence. It follows a structured format, developed and refined by an interdisciplinary team of counseling and education professionals, focusing on skill building and emotional support. It is an interactive group, encouraging active participation, and is flexible enough to accommodate specific needs of group members. Specific issues addressed include: child development and appropriate expectations, discipline vs. punishment, rewards and consequences, understanding feelings, changing behaviors, dealing with conflicts, nurturing, and recognizing warning signs of emotional disturbance.

Meeting Times: Wednesdays, 9:30–11:00 a.m.

Cost: $XX per week (individual or couple)

Group in progress, openings available

If you would like to register, or for further details, leave a message with (insert Practitioner's Name) at (insert Practitioner's Phone Number). Approximately nine sessions remain as of 3/1/XX.

(Sample Children's Group Announcement)

Self-Esteem Group for Children

Practitioner's Name
Practitioner's Address & Phone Number

A counseling group for children, grades K-5, designed to focus on the many components of self-esteem, is currently being formed. It will allow for exploration of self-concept, expression of feelings, and identification of strengths, and will include a number of activities focusing on these areas. Divorce and separation often have a profound impact on the self-esteem of children, creating the need for them to explore many of these issues as well. Topics include: personal strengths, cooperative problem-solving, effective communication, and assertiveness/personal power. Three half-hour meetings with parents will be incorporated into group sessions.

Group Size:	4-8 children
Starting Date:	Wednesday, October 11, 20XX
Meetings:	Wednesdays, 4:15–5:30 p.m. (to exclude 11/22/XX, before Thanksgiving)
Duration:	10 weeks
Cost:	$XXX total cost per child payable in five installments of $XX at 1st, 3rd, 5th, 7th, and 9th sessions (office staff can assist in determining insurance eligibility)
Registration:	**Required by Wednesday, December 21, 20XX**
To register, or for further details, call:	**(800) 555-1234 or (888) 555-5432**

(Insert Practitioner's Name), has been a counselor in both agency and private practice settings for the past XX years. He/she has presented counseling groups and workshops through area school districts and private schools since XXXX. His areas of specialization include....

Practitioner's Address

(Sample Children's Group Announcement for Schools)

Practitioner's Name
Practitioner's Address & Phone Number

Group Counseling for Children

*** Conflict Resolution * * Divorce/Separation * * Self-esteem ***

Each group consists of 8 weekly 50-minute sessions, and is available for grades K-2, 3-5, and 6-8 (grade levels may be configured differently if circumstances warrant).

Enrollment of up to 6 children per group.

Description of Groups

- ***Conflict Resolution***—for children having difficulty dealing appropriately with adults/peers. Topics include impulse control, anger management, problem-solving, cooperative interaction, and effective communication.

- ***Children in the Middle***—for children either currently dealing with and/or feeling effects of divorce/separation. Topics include dealing with feelings, adjusting to stepfamilies, stress management, and self-esteem building.

- ***Self-esteem***—for children experiencing difficulty feeling positively about themselves. Topics include identifying and expressing feelings, cooperative tasks, personal strengths, and coping with anxiety.

All groups are participatory and include activities such as drawing, role-playing, cooperative games and tasks, therapeutic games, selected readings and videos, and discussion. Group session summary outlines are available upon request.

Fee: $XXX per group—including 8 counseling sessions, materials, travel expenses, administrative record-keeping functions, and parent/school personnel contacts when appropriate.

Starting dates and times flexibly arranged. Groups with duration of more than 8 sessions available upon request (at accordingly higher fee).

Please call (insert Practitioner's Name) for further information or to arrange a group.

(Sample Workshop Announcement)

Practitioner's Name
Practitioner's Address & Phone Number

Communication with Children
The Empathic Response Method:
An On-site Workshop for Faculty & Staff

Offered By: Practitioner's Name

This 90-minute workshop is designed to foster more effective communication with children through the exploration of the empathic response method. Issues include:

- Four steps to good communication—attending, listening, thinking, responding
- Reflective listening and responding
- Effective conflict resolution

The workshop includes opportunities to practice techniques presented, utilizing an interactive format. Potential benefits include:

- Reducing conflict, both between adults and children as well as between peers
- Increasing children's self-esteem
- Creating a harmonious atmosphere from which comes a spirit of cooperation and satisfaction

An opportunity to ask questions regarding my services will be included as part of this workshop.

◆ CHAPTER SIX ◆

Managed Care

This section is designed to assist those desiring to become affiliated or expand contacts with Managed Care organizations, as well as to provide assistance in tracking managed care clients.

The following items are contained herein:

- Managed Care Organizations—Two Suggestions on Obtaining Contact Information
- Sample Letters of Inquiry
- Suggestions for Working with Managed Care Organizations
- Managed Care Update (Client Tracking Sheet)
- Sample Monthly EAP Billing Log
- Sample HCFA Form (Also in Billing Section)
- Sample Managed Care Treatment Update

Managed Care Organizations— Two Suggestions on Obtaining Contact Information

Two of the best resources I have come across for listings of managed care organizations in the mental health field are as follows:

1. **American Mental Health Counselors Association**—this organization will provide you with a list of several major players in the mental health field. Call AMHCA at (703) 823-9800 x383. Ask for publication *Guide To Behavioral Managed Care Firms.*

2. **Business Insurance Reporting Weekly,** June 27, 1994 issue. This issue contains extensive listings of Employee Assistance Programs (EAPs) and a "directory of managed mental health care networks." Call (800) 678-9595 or (313) 446-1611 to check on back issue availability. There is a charge for back issues, but it is less than $10. If back issues are no longer available, a trip to your municipal or hospital library would be advisable.

(Sample Managed Care Letter of Inquiry)

(Brief Version)

Date

Provider Relations
Managed Care Company
Street
City, State, Zip

Dear Provider Relations:

I am a counselor/therapist in a Vancouver, Washington, private practice, and am writing seeking your assistance. I would appreciate knowing if your organization is currently accepting applications for mental health providers in the greater Portland, Oregon/Southwest Washington area. If so, an application and/or description of the application process would be greatly appreciated. I am certified to practice in the state of Washington, have an M.A. in Psychology, and have access to supervision by psychiatrists and psychologists. If you require additional information prior to application, I would be pleased to provide it at your request.

I appreciate your assistance and consideration, and look forward to your reply.

Sincerely,

Practitioner's Name

(Sample Managed Care Letter of Inquiry)

(Extended Version)

Date

Provider Relations
Managed Care Company
Street
City, State, Zip

Dear Provider Relations:

I am a counselor/therapist in a downtown Vancouver, Washington, private practice writing to you in order to make inquiry into potential enrollment with your network of mental health providers. My practice emphasizes services to children, adolescents, and families, but is also open to adult clients, including couples. I am interested in contracting with your organization, or working on a similar arrangement whereby I could be approved to provide services to your subscribers, and would appreciate your consideration in this regard.

I have had an extensive amount of training and a wide variety of experiences in counseling, as my enclosed resume indicates. I am a specialist in play therapy, and have a therapeutic playroom available. My counseling approach focuses on empowerment; helping the client to develop life-long skills for coping and succeeding. It is a positive, productive approach that can be applied to both long and short-term counseling/therapy. My credentials are an M.A. in Psychology, with additional graduate-level training in counseling, and a license to practice as a certified counselor in the state of Washington. My practice is located in a suite of offices co-occupied by two psychiatrists, both of whom would be available for supervision if required. References and/or additional information will be provided upon request.

I appreciate your time and assistance in considering this correspondence. Please feel free to contact me at your convenience. I look forward to hearing from you, and hope you have an opportunity available.

Thank you.

Sincerely,

Practitioner's Name

Enclosure

Suggestions for Working with Managed Care Organizations

Should I or shouldn't I?—Determine whether or not you are ready to tackle what may seem at times to be a daunting task. Ask yourself "do I want to pursue managed care opportunities at this time?". Analyze positive vs. negative aspects of your decision, and act upon the conclusion which feels best for you.

Organization—Be sure to have a credential packet ready to photocopy and send when requested. Gather your resume, licenses, malpractice insurance, and board certifications, etc.

Allow time for the application process to proceed—Do not become discouraged or lose motivation if some companies do not respond in a timely fashion. Keep track of elapsed time, and follow up with companies that have not responded. It may take several months from initial inquiry to active network status.

Read all proposed contracts carefully—Make certain that you understand your contractual obligations and are able to fulfill them. Also examine the reimbursement schedule and make sure it is acceptable to you. Should you find any contractual stipulations which present a problem, contact the provider and ask if any amendments may be made to the contract. *Do not sign a contract with which you feel uncomfortable.*

Areas of specialization—Be sure to let the provider know if you have any particular areas of specialization, such as working with children, adolescents, or seniors. Other examples would include couples work, abuse issues, depression, ADHD, stress management, and substance abuse. By making the provider aware of your specialties, you increase the likelihood of receiving referrals.

How many networks do I join?—Since each managed care organization has its own set of rules and paperwork, be aware that dealing with too many companies can become a confusing and frustrating task. Start with a few, and add as you feel ready. Also, determine what percentage of your practice you feel comfortable with coming from managed care vs. other types of sources.

Your satisfaction with the organization—Politely express concerns to the company's provider relations department as they arise. If you become dissatisfied with a particular company, consider "firing" them by resigning from the network. Remember that satisfaction need be mutual and you are under no obligation to continue a contract, beyond stipulations concerning resignation, should you decide to do so.

Actively seek referrals—Often times, referrals will be few at first. Contact the managed care company from time to time to check on your status in network, and to politely remind them of your availability. Given time and cooperation, referrals will likely increase.

Practitioner's Name
Practitioner's Address & Phone Number

Managed Care Update

Date: _____

Client Name	Authorized Sessions Remaining	Reports Updates Pending	Date Required	Status

(Sample Completed Monthly EAP Billing Log)

Send Form To: **ABC Psychcare, Healthy Mind, USA**

Mary Sue Smith, M.A.
111 Main Street
Anytown, Anystate 11111

Date: 5/15/XX

Client Name	Insured's Name	Employer	Date of Session	Authorization Number	CPT Code	Charge
Smith, James	Smith, James	XYZ Doo Dads	04/30/XX	C3PO	90806	$65
Smith, Melissa	Smith, James	XYZ Doo Dads	05/06/XX	C3PO-1	90806	$65
Johnson, Atlee	Johnson, Atlee	HHH Entities	05/06/XX	R2D2	90847	$65

Total Number of Sessions Billed: 3
Total of Charges Billed: $195

Practitioner's Signature Date

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, James E.

3. PATIENT'S BIRTH DATE (MM DD YY): 03 15 85 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Smith, Rebecca H.

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Main Street

CITY: Vancouver STATE: WA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Vancouver STATE: WA

ZIP CODE: 98660 TELEPHONE (Include Area Code): (360) 123-4567

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 98660 TELEPHONE (Include Area Code): (360) 123-4567

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY): SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): SEX M [ ] F [X]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ABC Insurance Group

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File DATE: 05-01-XX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature On File

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (MM DD YY):

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)

1. 300.4
2. 313.81
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 16 XX	03 16 XX	11	9	90801		12	65.00					
2 03 23 XX	03 23 XX	11	9	90806		12	65.00					
3 03 30 XX	03 30 XX	11	9	90806		12	65.00					
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 987654321 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: Smith011

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 195.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 195.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Practitioner's Name

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Practitioner's Name & Address

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

(Sample Managed Care Treatment Update)

Managed Care Company
Name & Address

Treatment Update

Section I—Identifying Information

Patient's Name _____ Date of Birth: _____

Insured's Name: _____ Insured's SS #: _____

Insured's Employer: _____

Date of patient's first visit: _____ Current frequency of sessions: _____

Do you anticipate any change in this frequency/duration? Yes ☐ No ☐ Specify: _____

Total number of sessions requested: _____ Estimate total visits for current treatment: _____

Estimate termination date: _____

Section II—Diagnostic Information (use DSM-IV)

DSM-IV Diagnosis (all axes need to be completed for certification)

AXIS I _____ AXIS II _____ AXIS III _____

AXIS IV _____ AXIS V _____

(list stressors) (current GAFS)

Section III—Treatment Plan

	—Goals—	—Interventions/Treatment Modality—
A.		
B.		
C.		
D.		

(Sample Managed Care Treatment Update)

Section IV—Progress to Date (Describe in specific ways)

_____

_____

_____

_____

Section V—List Medications and Dosages

_____

_____

Any history or current indication of chemical dependency: Yes ☐ No ☐
If yes, please explain.

Section VI—Therapist Information

Physician/Therapist _____

Telephone Number _____

Social Security/Tax ID _____

Address: _____

_____

_____

_____

I hereby certify that I am the above named physician/therapist and have provided direct services to this patient and that the information is truthful, accurate and complete.

Signature _____ *Date:* _____

This form will not be processed without service provider signature

Please complete this form and return it to: XYZ Managed Health Corp.
Address

Concluding Remarks

I hope you have found this book to be of value, and wish you much success in your private practice endeavors. It has been said that we private practitioners are a "dying breed," to which I respond with a resounding "NOT SO FAST." While some managed care organizations and insurers would like to see options limited and we practitioners consolidated into "cooperative ventures," I believe that talk of the independent practitioner disappearing from the psychotherapy landscape is rhetoric. We have the skills and abilities to manage our practices well, and to find those niches which have yet to be overrun by the long arm of managed care.

While this book has been designed to assist psychotherapists with a range of practical issues, I would like to end it on a more philosophical note. I encourage you to follow your heart, stay true to your beliefs, and remain committed to your ethics and values—to actively struggle to assert your rights and the rights accorded our profession. With this in mind, you will succeed according to your definition of success. That is something no one can ever take away from you.

Warmest regards and best wishes.

Mark Vellucci

04

The AMHCA Handbook of Essential Forms and Marketing Strategies

Mark Vellucci

American Mental Health Counselors Association

SYSTEM REQUIREMENTS

Windows
- I486TM or Pentium® processor-based personal computer
- Microsoft® Windows® 95, Windows 98, or Windows NT® 4.0 with Service Pack 3 or later
- 10 MB of available RAM on Windows 95 and Windows 98 (16 MB recommended)
- 16 MB of available RAM on Windows NT (24 MB recommended)
- 10 MB of available hard-disk space

Macintosh
- Apple Power Macintosh or compatible computer
- Mac OS software version 7.1.2 or later
- 4.5 MB of available RAM (6.5 MB recommended)
- 8 MB of available hard-disk space

If your system does not meet these requirements, you may be able to make use of the older 3.0 version of Acrobat available from www.adobe.com.

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